(To Resolve Conflicts)

B-Engrossed
Senate Bill 97

Ordered by the House May 22
Including Senate Amendments dated April 12 and House Amendments
dated May 22 to resolve conflicts

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SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure.

Provides that Director of Department of Consumer and Business Services must act as, or acknowledge another regulatory official as, group-wide supervisor for internationally active insurance group. Specifies criteria for and conditions under which director must assume authority to act as group-wide supervisor or acknowledge other regulatory official's authority as group-wide supervisor. Specifies actions director may take as group-wide supervisor.

Requires insurer or insurance group to submit corporate governance annual disclosure to director, or other regulatory official in lead state, in accordance with schedule director specifies by rule. Specifies corporate level of organization at which insurer or insurance group may choose to make corporate governance annual disclosure.

Specifies confidentiality requirements for documents, materials and other information that director receives, obtains, creates or discloses to, or receives in disclosure from, another person. Specifies conditions under which director may share documents, materials or other information and requirements for recipients of shared documents, materials or other information.

Specifies that if director places insurer under supervision, liquidation or rehabilitation, director retains authority over insurer's operations and over transactions in which insurer engages within insurance holding company system of which insurer is member.

Specifies period within which health benefit plan carrier may cancel coverage in identified circumstances.

Becomes operative on January 1, 2018.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to modernizing insurance corporate governance; creating new provisions; amending ORS 732.245, 732.528, 732.548, 732.588, 732.592, 732.650, 734.230, 743B.013, 743B.105, 743B.125, 750.015, 750.055 and 750.085; and declaring an emergency.

Be It Enacted by the People of the State of Oregon:

SECTION 1. Sections 2 and 3 of this 2017 Act are added to and made a part of ORS 732.517 to 732.592.

SECTION 2. (1) The Director of the Department of Consumer and Business Services shall:

(a) Act, in accordance with the provisions of this section, as the group-wide supervisor for any internationally active insurance group; or

(b) Acknowledge another regulatory official as the group-wide supervisor for an internationally active insurance group if the internationally active insurance group:

(A) Does not have substantial insurance operations in the United States;

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

(B) Has substantial insurance operations in the United States but not in this state; or

(C) Has substantial insurance operations in this state but the director determines under criteria set forth in subsections (2) and (6) of this section that the other regulatory official is the appropriate group-wide supervisor.

(2) The director, in cooperation with other state, federal and international regulatory agencies, shall identify a single group-wide supervisor for each internationally active insurance group. The director may determine that the director is the appropriate group-wide supervisor for an internationally active insurance group with substantial insurance operations in this state or the director may determine that another regulatory official is the appropriate group-wide supervisor. In making the determination, the director shall consider:

(a) Where the insurers that have the largest share of the internationally active insurance group's written premiums, assets or liabilities are domiciled;

(b) Where the top-tier insurers within the internationally active insurance group's insurance holding company system are domiciled;

(c) Where the internationally active insurance group has executive offices or the group's largest operational offices;

(d) Whether another regulatory official is acting, or seeks to act, as the group-wide supervisor for the internationally active insurance group under a regulatory system that the director determines is:

(A) Substantially similar to the regulations set forth in the Insurance Code; or

(B) Otherwise sufficient to enable the regulatory official to engage in group-wide supervision and enterprise risk analysis and to cooperate with other regulatory officials; and

(e) Whether another regulatory official that is acting, or seeks to act, as the group-wide supervisor provides the director with a reasonable degree of reciprocal acknowledgment and cooperation.

(3) A regulatory official that the director determines under subsection (2) of this section is the appropriate group-wide supervisor for an internationally active insurance group may in turn acknowledge a different regulatory official as the appropriate group-wide supervisor. Before acknowledging another regulatory official as an appropriate group-wide supervisor, a regulatory official shall:

(a) Consider the criteria set forth in subsection (2) of this section;

(b) Cooperate with and obtain acknowledgment from other regulatory officials with responsibility for supervising the internationally active insurance group; and

(c) Consult with the internationally active insurance group.

(4) Notwithstanding any other provision of this section or section 3 of this 2017 Act, the director shall acknowledge another regulatory official that is acting as a group-wide supervisor for an internationally active insurance group unless a material change in the internationally active insurance group requires the director to make a determination under subsection (2) of this section as to the appropriate group-wide supervisor for the internationally active insurance group. For purposes of this determination, a material change is:

(a) Insurers domiciled within this state come to hold the largest share of the internationally active insurance group's written premiums, assets or liabilities; or

(b) The top-tier insurers within the internationally active insurance group's insurance holding company system become domiciled in this state.

(5) The director, in accordance with ORS 732.584, may order an insurer registered under

ORS 732.551 to produce any information the director requires to determine whether the director may act as, or must acknowledge another regulatory official as, the group-wide supervisor for an internationally active insurance group. Before determining that the director is the appropriate group-wide supervisor for an internationally active insurance group, the director shall inform the insurer that provided the information and the controlling entity within the internationally active insurance group, and give the internationally active insurance group at least 30 days in which to provide any additional information that may relate to the director's determination. The director shall identify internationally active insurance groups for which the director acts as the group-wide supervisor on the Department of Consumer and Business Services website.

(6) As the group-wide supervisor for an internationally active insurance group, the director may:

(a) Assess enterprise risks within the internationally active insurance group to evaluate whether persons who manage members of the internationally active insurance group that are engaged in transacting insurance have identified the members' material financial condition and liquidity risks and have established reasonable and effective mitigation measures;

(b) Request from any member of an internationally active insurance group subject to the director's supervision information that is necessary and appropriate to enable the director to assess enterprise risk for the member, including information about the member's:

(A) Governance, risk assessment and management;

(B) Capital adequacy; and

(C) Material intercompany transactions;

(c) Require members of internationally active insurance groups to develop and implement reasonable measures to enable the members to timely recognize and mitigate enterprise risks and, if necessary, assist the members or ask regulatory officials in jurisdictions in which the members are domiciled to compel the members to develop and implement the measures;

(d) Communicate and share information, including through a supervisory college described in ORS 732.571, with other state, federal and international regulatory agencies that have authority over members of internationally active insurance groups, subject to the confidentiality provisions of ORS 705.137, 705.138, 705.139 and 732.586;

(e) Enter into agreements with, or obtain information from, any insurer registered under ORS 732.551, any member of an internationally active insurance group or any other state, federal or international regulatory agency with authority over the internationally active insurance group in order to clarify or provide a basis for the director's authority as a group-wide supervisor, provided that the agreements or information:

(A) Enable the director to resolve disputes with other regulatory officials; and

(B) Will not serve as evidence in any proceeding that an insurer or person within an insurance holding company system that is not domiciled or organized in this state is transacting insurance in this state or is otherwise subject to the jurisdiction of this state; or

(f) Perform any other activities the director deems necessary to exercise the functions of a group-wide supervisor, provided the activities are consistent with the authority and the purposes set forth in this section.

(7)(a) The director may cooperate, including through a supervisory college described in ORS 732.571, with another regulatory official from a jurisdiction that the National Associ-

ation of Insurance Commissioners has not accredited in the regulatory official's role as a group-wide supervisor if:

(A) The director acknowledges the regulatory official as a group-wide supervisor;

(B) The director's cooperation complies with the laws of this state; and

(C) The regulatory official cooperates with the director's activities as a group-wide supervisor for other internationally active insurance groups as appropriate.

(b) The director may refuse to acknowledge and cooperate with a regulatory official who does not reciprocate the director's acknowledgment and cooperation under this subsection.

(8) The director may enter into agreements with or obtain information from an insurer registered under ORS 732.551, an affiliate of the insurer and any other state, federal or international regulatory agency if the agreement or information clarifies or provides the basis for a regulatory official's authority as a group-wide supervisor.

(9) An insurer that is subject to this section, or that is a member of an internationally active insurance group that is subject to this section, shall pay the director's reasonable expenses of administering this section, including expenses associated with engaging attorneys, actuaries or other professionals and reasonable travel expenses.

SECTION 3. An insurance holding company system that is not an internationally active insurance group may request that the Director of the Department of Consumer and Business Services determine or acknowledge a group-wide supervisor for the insurance holding company system in accordance with section 2 of this 2017 Act.

SECTION 4. Sections 5 to 8 of this 2017 Act are added to and made a part of ORS 732.650 to 732.672.

SECTION 5. (1) An insurer, or the insurance group of which an insurer is a member, each year in accordance with a schedule the Director of the Department of Consumer and Business Services establishes in consultation with the insurer or insurance group, shall submit to the director or to the chief insurance regulatory official in the state that the director determines is the lead state for the insurance group, a corporate governance annual disclosure that has the information described in section 6 of this 2017 Act. The director shall determine the lead state in accordance with procedures that the director adopts by rule after considering procedures that are set forth in a financial analysis handbook that the National Association of Insurance Commissioners has adopted. An insurer or a member of an insurance group that is not subject to the requirement under this subsection to submit a disclosure shall nevertheless submit the disclosure at the director's request.

(2) The chief executive officer or corporate secretary of an insurer or insurance group shall sign the corporate governance annual disclosure and attest that to the best of the officer's or secretary's belief and knowledge the insurer or insurance group has implemented the corporate governance practices identified in the disclosure and that the insurer's or insurance group's board of directors, or an appropriate committee of the board of directors, has received a copy of the disclosure.

(3)(a) An insurer or insurance group that submits a corporate governance annual disclosure under subsection (1) of this section may provide information in the disclosure:

(A) At the level of the individual legal entity, an intermediate holding company or the controlling parent company, depending on how the insurer or insurance group has structured corporate governance;

(B) At the level at which the insurer or insurance group determines the extent to which

the insurer or insurance group will accept risk;

(C) At the level at which the insurer or insurance group collectively oversees or coordinates and exercises supervision over the insurer's or insurance group's earnings, capital, liquidity operations and reputation; or

(D) At the level at which legal liability for failing in the duties of general corporate governance would occur.

(b) An insurer or insurance group that determines the level at which the insurer or insurance group provides information in the corporate governance annual disclosure under paragraph (a)(B), (C) or (D) of this subsection shall indicate which criteria the insurer or insurance group used for the disclosure and explain any subsequent changes in the level at which the disclosure occurs.

(4) If the director has determined a lead state in accordance with the procedures set forth in the financial analysis handbook described in subsection (1) of this section, an appropriate official in the lead state shall review the corporate governance annual disclosure and request any other information necessary for the review.

(5) An insurer or insurance group that provides information that is substantially similar to the information required under this section or section 6 of this 2017 Act in other documents that the insurer or insurance group submits to the director, including proxy statements in conjunction with Form B requirements or other state or federal filings, need not duplicate the information in the corporate governance annual disclosure, but must include in the documents the insurer or insurance group submits to the director a cross-reference to documents that have the required information.

SECTION 6. (1) An insurer or insurance group has discretion as to the form and content of the insurer's or insurance group's responses to inquiries in a corporate governance annual disclosure so long as the responses provide information the Director of the Department of Consumer and Business Services requires to understand the insurer's or insurance group's corporate governance structure, policies and practices. The director may request additional information the director deems material and necessary to enable a clear understanding of the corporate governance policies and the reporting, information systems or controls that implement the policies.

(2) Notwithstanding the discretion permitted to an insurer or insurance group under subsection (1) of this section, the insurer or insurance group shall prepare the corporate governance annual disclosure in a manner consistent with rules the director adopts under section 5 of this 2017 Act. The insurer or insurance group shall maintain documentation and supporting information for the corporate governance annual disclosure and make the documentation and supporting information available during an examination of the insurer or insurance group or otherwise at the director's request.

SECTION 7. (1)(a) Documents, materials or other information, including a corporate governance annual disclosure, that the Director of the Department of Consumer and Business Services discloses to, or receives in a submission or disclosure from, another person or otherwise possesses, controls, obtains or creates in accordance with section 5 or 6 of this 2017 Act contains trade secrets, is proprietary, confidential and privileged and is not subject to:

(A) Disclosure under ORS 192.410 to 192.505;

(B) Subpoena; or

(C) Discovery and is not admissible in evidence in a private civil action.

(b) The director may use documents, materials or other information described in paragraph (a) of this subsection in any regulatory or legal action to carry out the director's official duties without the prior written consent of the insurer or insurance group that provided or served as a source or subject of the documents, materials or other information but the director may not otherwise make the documents, materials or other information available to the public without prior written consent from the insurer or insurance group.

(c) The director, any person that acted under the director's authority in an examination or other regulatory action or any person that under section 5 or 6 of this 2017 Act received shared documents, materials or other information described in paragraph (a) of this subsection may not testify concerning the documents, materials or other information in any private civil action.

(2)(a) The director, in performing the director's regulatory duties, may:

(A) Share documents, materials and other information described in subsection (1)(a) of this section, including information in or related to a corporate governance annual disclosure, with other state, federal or international regulatory agencies, including members of a supervisory college described in ORS 732.571, with the National Association of Insurance Commissioners and with consultants identified in section 8 of this 2017 Act if a regulatory agency, the association or a consultant requests the documents, materials or other information and:

(i) Agrees in writing to maintain any privilege that applies to, and to keep confidential, the documents, materials and other information; and

(ii) Verifies in writing that the regulatory agency, the association or the consultant has legal authority to keep the documents, materials and other information confidential.

(B) Receive documents, materials and other information described in subsection (1)(a) of this section from the National Association of Insurance Commissioners and other state, federal and international regulatory agencies, including members of a supervisory college described in ORS 732.571.

(b) The director shall maintain any privilege that applies to, and keep confidential, any documents, materials or other information the director receives from any of the persons described in paragraph (a)(B) of this subsection with notice or an understanding that the documents, materials or information are privileged or are confidential under the laws of the jurisdiction in which the person that is the source or subject of the documents, materials or other information is domiciled or exercises regulatory authority.

(3) The director's or another person's disclosure of documents, materials or other information described in this section does not waive any privilege or claim of confidentiality that otherwise applies to the documents, materials or other information.

SECTION 8. (1)(a) The Director of the Department of Consumer and Business Services, at the expense of the insurer or insurance group from which the director receives a corporate governance annual disclosure, may retain a consultant, including an attorney, actuary, accountant or other expert, whenever the director reasonably requires assistance to review the corporate governance annual disclosure or related information and to evaluate the insurer's or insurance group's compliance with sections 5, 6, 7 and 8 of this 2017 Act.

(b) A consultant that the director retains under paragraph (a) of this subsection shall:

(A) Act solely under the director's supervision;

(B) Serve only in an advisory capacity; and

(C) Comply with the requirements for confidentiality set forth for the director in section 7 of this 2017 Act.

(2) The director may not retain a consultant unless the consultant demonstrates to the director that the consultant:

(a) Does not have a conflict of interest; and

(b) Has internal procedures that enable the consultant to:

(A) Monitor and avoid conflicts of interest; and

(B) Comply with the requirements for confidentiality set forth for the director in section 7 of this 2017 Act.

(3) The director shall enter into a written agreement with a consultant that the director retains under subsection (1) of this section, or with the National Association of Insurance Commissioners if the director consults with the association, that specifies how the consultant or association may share and use documents, materials or other information described in section 7 (1)(a) of this 2017 Act. The terms of the agreement must require the consultant or association to obtain written permission from the insurer or insurance group that is the source or subject of the documents, materials or other information before making the documents, materials or other information public and must specify:

(a) Procedures and protocols for keeping the documents, materials and other information secure and confidential;

(b) Conditions under which the consultant or the association may share the documents, materials or other information, including requirements that the recipient of the documents, materials or other information must:

(A) Agree in writing to keep the documents, materials and other information secure and confidential; and

(B) Verify in writing that the consultant or association has legal authority to keep the documents, materials or other information secure and confidential;

(c) That the consultant or association may share the documents, materials and other information only with regulatory agencies in states that are domiciles of the insurer that is the source or subject of the documents, materials or other information or of an insurer within the insurance group that is the source or subject of the documents, materials or other information;

(d) That the director retains ownership and control of the documents, materials or other information and that the consultant or association may use the documents, materials or other information only in accordance with the director's specifications or under the director's supervision;

(e) That the consultant or association may not store the documents, materials or other information in a permanent database or another form after the consultant or association completes the consultation or finishes assisting the director;

(f) That the consultant or association must immediately notify the director and the insurer or insurance group that is the source or subject of the documents, materials or other information if the consultant or association receives a subpoena or other request to disclose or produce the documents, materials or other information; and

(g) That the consultant or association agrees to permit the insurer or insurance group that is the source or subject of the documents, materials or other information to intervene in any administrative or judicial proceeding that might require the consultant or association

to disclose or produce the documents, materials or other information.

SECTION 9. ORS 732.245 is amended to read:

732.245. (1) **Except as provided in subsection (4) of this section,** every domestic insurer shall have and maintain [*its*] **the domestic insurer's** principal place of business and home office in this state, and shall keep [*therein*] **within this state** accurate and complete accounts and records of [*its*] **the domestic insurer's** assets, transactions, and affairs in accordance with the provisions of the Insurance Code.

(2) Every domestic insurer shall have and maintain [*its*] **the domestic insurer's** assets in this state, except as to:

(a) Real property and personal property appurtenant [*thereto*] **to real property that is** lawfully owned by the insurer and located outside this state; and

(b) Such property of the insurer as may be customary, necessary and convenient to enable and facilitate the operation of [*its*] **the domestic insurer's** branch offices and regional home offices located outside this state as referred to in subsection (4) of this section.

(3) Removal or attempted removal of all or a material part of the records or assets of a domestic insurer from this state except pursuant to a merger approved by the Director of the Department of Consumer and Business Services under ORS 732.517 to 732.546, or for such reasonable purposes and periods of time as may be approved by the director in writing in advance of such removal, or concealment or attempted concealment of [*such*] records or assets or [*such*] **a** material part [*thereof*] **of the records or assets** from the director, is prohibited. [*Upon violation of this section, the director may institute delinquency proceedings against the insurer as provided in ORS 734.150*] **The director may apply under ORS 734.150 for an order to rehabilitate a domestic insurer that violates this section**.

(4)(a) A domestic insurer that has and maintains a principal place of business and a home office in this state may keep electronic records in this or another state. If the domestic insurer keeps electronic records in another state, the domestic insurer shall provide the director with access to the electronic records in a manner that allows the director to examine the insurer as if the electronic records were located in this state.

(b) A domestic insurer complies with the requirement set forth in paragraph (a) of this subsection if the domestic insurer:

(A) Provides the director with electronic access to, or printed copies of, all records that the director determines are necessary to conduct an examination of the domestic insurer:

(i) Within 24 hours after the director requests the records or at a mutually agreed time;

(ii) At the domestic insurer's principal place of business or home office in this state; and

(iii) With in-person or telephone access to the person that prepared the records, if the director requests access to the person; or

(B) Makes the records available for examination at an office outside this state if the domestic insurer pays the director's transportation and related expenses as provided in ORS 731.316.

[*(4)*] **(5)** This section [*shall*] **does** not prohibit an insurer from:

(a) Establishing and maintaining branch offices or regional home offices in other states where necessary or convenient to the transaction of [*its*] **the domestic insurer's** business, and keeping therein the detailed records and assets customary and necessary for the servicing of [*its*] **the domestic insurer's** insurance in force and affairs in the territory served by [*such an*] **the** office, as long as such records and assets are made readily available at such office for examination by the

director at the director's request;

(b) Having, depositing or transmitting funds and assets of the insurer in or to jurisdictions outside of this state required by the law of such jurisdiction or as reasonably and customarily required in the regular course of [*its*] **the domestic insurer's** business; or

(c) Using custodial arrangements for the holding of securities owned by the insurer, either in or outside of this state, and either segregated from or commingled with securities owned by others, if the arrangements conform to rules adopted by the director for safeguarding the assets and facilitating the director's examination of insurers using such custodial arrangements.

SECTION 10. ORS 732.548 is amended to read:

732.548. As used in ORS 732.517 to 732.592:

(1) "Affiliate" means a person that directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with, another person.

(2) "Control" means possessing the direct or indirect power to manage a person or set the person's policies, whether by owning voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position or corporate office the person holds.

(3) "Enterprise risk" means an activity, circumstance, event or series of events that involve one or more of an insurer's affiliates and that, if not remedied promptly, are likely to have an adverse material effect on the insurer's or the insurance holding company system's financial condition or liquidity, including but not limited to an activity, circumstance, event or series of events that would cause the insurer's risk-based capital to fall into company action level or cause the Director of the Department of Consumer and Business Services to determine under ORS 731.385 that the insurer is in hazardous financial condition.

(4) "Group-wide supervisor" means a regulatory official that has the authority to conduct and coordinate supervisory activities for an internationally active insurance group under section 2 of this 2017 Act.

[*(4)*] **(5)** "Insurance holding company system" means two or more affiliated persons, one or more of which is an insurer, and includes a financial holding company as described in section 103 of the federal Gramm-Leach-Bliley Act (P.L. 106-102).

[*(5)*] **(6)** "Insurer" has the meaning given that term in ORS 731.106 but does not include an agency, authority or instrumentality of the United States, the Commonwealth of Puerto Rico, another state or a political subdivision of another state.

(7) "Internationally active insurance group" means an insurance holding company system that includes an insurer that is registered under ORS 732.551 and that:

(a) Writes premiums in three or more countries;

(b) Writes 10 percent or more of the insurance holding company system's total gross written premiums outside the United States; and

(c) Has $50 billion or more of total assets, or $10 billion or more of total gross written premiums, based on a three-year rolling average.

[*(6)(a)*] **(8)(a)** "Person" means an individual, corporation, limited liability company, partnership, association, joint stock company, trust[,] **or** unincorporated organization**,** or [*a similar*] **an** entity or combination of entities [*that are*] **similar to the entities** described in this [*subsection*] **paragraph**.

(b) "Person" does not include:

(A) A joint venture partnership that is engaged exclusively in owning, managing, leasing or developing real or tangible personal property; or

(B) For the purposes of ORS 732.518, 732.521, 732.523, 732.526 and 732.528, a securities broker that holds, in the usual and customary broker's function, less than 20 percent of the voting securities of an insurer or of any person that controls an insurer.

[*(7)*] **(9)** "Security holder" means a person that owns a security of another person, including a security denominated as common stock, preferred stock or a debt obligation and any instrument that is convertible into or that is evidence of the right to acquire the security of another person.

[*(8)*] **(10)** "Subsidiary" means an affiliate that a person controls directly or indirectly through one or more intermediaries.

[*(9)*] **(11)** "Voting security" means a security that entitles the owner or holder of the security to vote at a meeting of shareholders, including a security that is convertible into a voting security or that is evidence of a right to acquire a voting security.

SECTION 11. ORS 732.528 is amended to read:

732.528. (1) The Director of the Department of Consumer and Business Services shall make a determination concerning the proposed activity described in ORS 732.521 (1) [*not later than the 60th day*] **within a period that begins 60 days** before the effective date of the activity. The director may refuse, after a public hearing, to approve a proposed activity if:

(a) The activity is contrary to law or would result in a prohibited combination of risks or classes of insurance.

(b) The activity is inequitable or unfair to the policyholders or shareholders of any insurer involved in, or to any other person affected by, the proposed activity. However, in connection with an acquisition of the insurer's voting securities from the insurer's shareholders, the director shall evaluate whether the proposed acquisition is fair to the shareholders of the insurer to be acquired only with respect to any shareholders that are unaffiliated with the acquiring party or parties and that would remain after the acquisition is completed.

(c) The activity would substantially reduce the security of and service to be rendered to policyholders of any domestic insurer involved in the proposed activity, or would otherwise prejudice the interests of such policyholders in this state or elsewhere.

(d) The activity provides for a foreign or alien insurer to be an acquiring party, and the director further finds that the insurer cannot satisfy the requirements of this state for transacting an insurance business involving the classes of insurance affected by the activity.

(e) The activity or the completion of the activity would substantially diminish competition in insurance in this state or tend to create a monopoly. In determining whether the activity would substantially diminish competition in insurance in this state or tend to create a monopoly, the director:

(A) Shall require the information described in ORS 732.539 and apply the standards set forth in ORS 732.542.

(B) May not disapprove the activity if the director finds that the activity would yield substantial economies of scale or increase the availability of insurance as provided in ORS 732.542 (9).

(C) May condition the director's approval of the activity on a party's removing the basis for the director's disapproval within a specific period of time.

(f) After the change of control or ownership, the domestic insurer to which the activity described in ORS 732.521 (1) applies would not be able to satisfy the requirements for receiving a certificate of authority to transact the line or lines of insurance for which the domestic insurer is currently authorized.

(g) The financial condition of any acquiring party might jeopardize the financial stability of the

insurer.

(h) The plans or proposals that the acquiring party has to liquidate the insurer, sell the insurer's assets or consolidate or merge the insurer with any person, or to make any other material change in the insurer's business or corporate structure or management, are unfair and unreasonable to the insurer's policyholders and not in the public interest.

(i) The competence, experience and integrity of the persons that would control the operation of the insurer are such that permitting the activity or permitting completion of the activity would not be in the interest of the insurer's policyholders and the public.

(j) The activity or completing the activity is likely to be hazardous or prejudicial to the insurance-buying public.

(k) The activity is subject to other material and reasonable objections.

(2) If the director disapproves the proposed activity, the director shall promptly notify, in writing, each insurer and each acquiring party involved in the proposed activity, specifying the bases, factors and reasons for the disapproval and giving each insurer and each acquiring party that filed the statement relating to the proposed activity an opportunity to amend the statement, if possible, to obviate the director's objections.

(3) If the director determines that a party that acquires control of a domestic insurer must maintain or restore the domestic insurer's capital to a level required under the laws and rules of this state, the director shall make and communicate the determination to the acquiring party not later than 60 days after the acquiring party files the statement required under ORS 732.523.

(4) The acquiring party or parties that filed a statement of acquisition under ORS 732.523 shall file any amendment to the statement that responds to the director's objection and, if a hearing was held on the proposed activity, shall resubmit the amendment at a hearing held under this section unless the director finds that a hearing is not necessary to protect the policyholders, shareholders or any other person the proposed activity affects.

(5) The director may retain at the acquiring party's expense any actuaries, accountants and other experts not otherwise a part of the director's staff as the director may reasonably need to assist the director in reviewing the proposed activity.

(6) The director may establish the effective date of an activity to which ORS 732.521 (1) applies in the order that approves the activity.

(7) Within 60 days after receiving a notice of approval or disapproval, any insurer or other party to a proposed activity, including the insurer subject to the acquisition, may appeal the director's final order as provided in ORS chapter 183. For purposes of the judicial review, the specifications the director must set forth in the director's written notice are the findings of fact and conclusions of law of the Department of Consumer and Business Services.

(8) On petition to the court, the court's power extends to affirming the order of the director, modifying all or any part of the director's objections, adding additional objections, approving the proposed activity as submitted or subject to such modifications or changes as the court may find proper, and requiring resubmission to the boards of directors or other governing bodies or for hearing as provided in ORS 732.526.

SECTION 12. ORS 732.588 is amended to read:

732.588. (1) If the Director of the Department of Consumer and Business Services determines that a person's violation of any provision of ORS 732.517 to 732.592 so impairs the financial condition of a domestic insurer as to threaten insolvency or makes the insurer's further transaction of business hazardous to the insurer's policyholders, creditors, shareholders or the public, the director

may place the insurer under supervision or in rehabilitation or liquidation as provided in ORS chapter 734.

(2) If the director determines that a person's violation of ORS 732.521, 732.523, 732.526, 732.541 or 732.566 prevents the director from fully understanding the enterprise risk that an insurance holding company system or an affiliate of an insurer presents to the insurer, the director may, on the basis of the violation, disapprove a dividend or distribution and may place the insurer under supervision as provided in subsection (1) of this section.

(3) If the director places an insurer under supervision as provided in ORS chapter 734 and the insurer engages in transactions within an insurance holding company system as provided in ORS 732.574, the director retains authority over the insurer's operations and over transactions in which the insurer engages within an insurance holding company system of which the insurer is a member.

SECTION 13. ORS 732.592 is amended to read:

732.592. (1) If an order for liquidation or rehabilitation of a domestic insurer has been entered, the receiver appointed under the order may recover, on behalf of the insurer, from any parent corporation or holding company or person or affiliate who otherwise controlled the insurer, the amount of distributions, other than distributions of shares of the same class of stock, paid by the insurer on [*its*] **the insurer's** capital stock, or any payment in the form of a bonus, termination settlement or extraordinary lump sum salary adjustment made by the insurer or [*its*] **the insurer's** subsidiary to a director, officer or employee, when such a distribution or payment is made at any time during the 12 calendar months preceding the petition for liquidation, conservation or rehabilitation, as the case may be, subject to the limitations of subsections (2), (3) and (4) of this section.

(2) A distribution to which subsection (1) of this section applies is not recoverable if the parent or affiliate shows that the distribution was lawful and reasonable when paid and that the insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the insurer to fulfill [*its*] **the insurer's** contractual obligations.

(3) Any person who was a parent corporation or holding company or a person who otherwise controlled the insurer or affiliate at the time a distribution to which subsection (1) of this section applies was paid [*shall be*] **is** liable in an amount that is not more than the amount of distributions or payments received by the person under subsection (1) of this section. Any person who otherwise controlled the insurer at the time such distributions were declared [*shall be*] **is** liable up to the amount of distributions the person would have received if the distributions had been paid immediately. If two or more persons are liable with respect to the same distributions, [*they shall be*] **the persons are** jointly and severally liable.

(4) The maximum amount recoverable under this section is the amount needed in excess of all other available assets of the impaired or insolvent insurer to pay the contractual obligations of the impaired or insolvent insurer and to reimburse any guaranty funds.

(5) To the extent that any person liable under subsection (3) of this section is insolvent or otherwise fails to pay claims due from the person pursuant to subsection (3) of this section, [*its*] **the person's** parent corporation or holding company or other person who otherwise controlled the person liable under subsection (3) of this section when the distribution was paid [*shall be*] **are** jointly and severally liable for any resulting deficiency in the amount recovered from the parent corporation or holding company or person who otherwise controlled [*it*] **the person liable under subsection (3) of this section**.

(6) If the director places an insurer under liquidation or rehabilitation as provided in ORS

chapter 734 and the insurer engages in transactions within an insurance holding company system as provided in ORS 732.574, the director retains authority over the insurer's operations and over transactions in which the insurer engages within an insurance holding company system of which the insurer is a member.

SECTION 14. ORS 732.650 is amended to read:

732.650. As used in ORS 732.650 to 732.672:

(1) "Corporate governance annual disclosure" means a report that an insurer or insurance group files with the Director of the Department of Consumer and Business Services in accordance with sections 5 and 6 of this 2017 Act.

[*(1)*] **(2)** "Insurance group" means insurers and affiliates within an insurance holding company system, as defined in ORS 732.548.

[*(2)*] **(3)** "Insurer" has the meaning given that term in ORS 732.548.

[*(3)*] **(4)** "Own risk and solvency assessment" means a confidential internal assessment of the material and relevant risks associated with an insurer's or insurance group's business plan and of the sufficiency of capital resources to support the business plan that the insurer or insurance group conducts and that is appropriate for the nature, scale and complexity of the insurer or insurance group.

[*(4)*] **(5)** "Own Risk and Solvency Assessment Guidance Manual" means the Own Risk and Solvency Assessment Guidance Manual that the National Association of Insurance Commissioners develops and adopts and that the Director of the Department of Consumer and Business Services by rule or order designates as guidance and standards for completing an own risk and solvency assessment.

[*(5)*] **(6)** "Own risk and solvency assessment summary report" means a confidential high-level summary of an insurer's or insurance group's own risk and solvency assessment.

SECTION 15. ORS 734.230 is amended to read:

734.230. In connection with **supervising an insurer under the Insurance Code or conducting** delinquency proceedings, the Director of the Department of Consumer and Business Services may appoint one or more special deputy directors to act for the director, and may employ such counsel, clerks, and assistants as the director deems necessary. Unless otherwise provided by the director, [*no*] **a** person so appointed [*shall be deemed*] **is not** a state employee solely by reason of such appointment. The compensation of the special deputies, counsel, clerks or assistants and all expenses of **supervising the insurer under the Insurance Code or** taking possession of [*the*] **a** delinquent insurer and [*of*] conducting [*the*] delinquency proceedings [*shall*] **must** be paid out of the funds or assets of the insurer. [*Within the limits of the duties imposed upon them special deputies shall possess all the powers given to, and, in the exercise of those powers, shall be subject to all the duties imposed upon, the receiver with respect to delinquency proceedings.*] **A special deputy acting within limits the director imposes with respect to supervising an insurer under the Insurance Code or conducting delinquency proceedings has a receiver's powers and is subject to a receiver's duties.**

SECTION 16. ORS 743B.013 is amended to read:

743B.013. (1) A health benefit plan issued to a small employer:

(a) Other than a grandfathered health plan, must cover essential health benefits consistent with 42 U.S.C. 300gg-11.

(b) May require an affiliation period that does not exceed two months for an enrollee or 90 days for a late enrollee.

(c) May not apply a preexisting condition exclusion to any enrollee.

(2) Late enrollees in a small employer health benefit plan may be subjected to a group eligibility waiting period that does not exceed 90 days.

(3) Each small employer health benefit plan [*shall be*] **is** renewable with respect to all eligible enrollees at the option of the policyholder, small employer or contract holder unless:

(a) The policyholder, small employer or contract holder fails to pay the required premiums.

(b) The policyholder, small employer or contract holder or, with respect to coverage of individual enrollees, an enrollee or a representative of an enrollee engages in fraud or makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan.

(c) The number of enrollees covered under the plan is less than the number or percentage of enrollees required by participation requirements under the plan.

(d) The small employer fails to comply with the contribution requirements under the health benefit plan.

(e) The carrier discontinues both offering and renewing all of [*its*] **the carrier's** small employer health benefit plans in this state or in a specified service area within this state. In order to discontinue plans under this paragraph, the carrier:

(A) Must give notice of the decision to the Department of Consumer and Business Services and to all policyholders covered by the plans;

(B) May not cancel coverage under the plans for 180 days after the date of the notice required under subparagraph (A) of this paragraph if coverage is discontinued in the entire state or[*, except as provided in subparagraph (C) of this paragraph,*] in a specified service area[*; and*]**, except that:**

(i) The carrier shall cancel coverage in accordance with subparagraph (C) of this paragraph if the cancellation is for a specified service area in the circumstances described in subparagraph (C) of this paragraph; and

(ii) The Director of the Department of Consumer and Business Services may specify a cancellation date other than the cancellation date specified in this subparagraph if the carrier is subject to a delinquency proceeding, as defined in ORS 734.014; and

(C) May not cancel coverage under the plans for 90 days after the date of the notice required under subparagraph (A) of this paragraph if coverage is discontinued in a specified service area because of an inability to reach an agreement with the health care providers or organization of health care providers to provide services under the plans within the service area.

(f) The carrier discontinues both offering and renewing a small employer health benefit plan in a specified service area within this state because of an inability to reach an agreement with the health care providers or organization of health care providers to provide services under the plan within the service area. In order to discontinue a plan under this paragraph, the carrier:

(A) Must give notice to the department and to all policyholders covered by the plan;

(B) May not cancel coverage under the plan for 90 days after the date of the notice required under subparagraph (A) of this paragraph; and

(C) Must offer in writing to each small employer covered by the plan, all other small employer health benefit plans that the carrier offers to small employers in the specified service area. The carrier shall issue any such plans pursuant to the provisions of ORS 743B.010 to 743B.013. The carrier shall offer the plans at least 90 days prior to discontinuation.

(g) The carrier discontinues both offering and renewing a health benefit plan, other than a grandfathered health plan, for all small employers in this state or in a specified service area within this state, other than a plan discontinued under paragraph (f) of this subsection.

(h) The carrier discontinues both offering and renewing a grandfathered health plan for all small employers in this state or in a specified service area within this state, other than a plan discontinued under paragraph (f) of this subsection.

(i) With respect to plans that are being discontinued under paragraph (g) or (h) of this subsection, the carrier must:

(A) Offer in writing to each small employer covered by the plan, all other health benefit plans that the carrier offers to small employers in the specified service area.

(B) Issue any such plans pursuant to the provisions of ORS 743B.010 to 743B.013.

(C) Offer the plans at least 90 days prior to discontinuation.

(D) Act uniformly without regard to the claims experience of the affected policyholders or the health status of any current or prospective enrollee.

(j) The Director of the Department of Consumer and Business Services orders the carrier to discontinue coverage in accordance with procedures specified or approved by the director upon finding that the continuation of the coverage would:

(A) Not be in the best interests of the enrollees; or

(B) Impair the carrier's ability to meet contractual obligations.

(k) In the case of a small employer health benefit plan that delivers covered services through a specified network of health care providers, there is no longer any enrollee who lives, resides or works in the service area of the provider network.

(L) In the case of a health benefit plan that is offered in the small employer market only to one or more bona fide associations, the membership of an employer in the association ceases and the termination of coverage is not related to the health status of any enrollee.

(4) A carrier may modify a small employer health benefit plan at the time of coverage renewal. The modification is not a discontinuation of the plan under subsection (3)(e), (g) and (h) of this section.

(5) Notwithstanding any provision of subsection (3) of this section to the contrary, a carrier may not rescind the coverage of an enrollee in a small employer health benefit plan unless:

(a) The enrollee or a person seeking coverage on behalf of the enrollee:

(A) Performs an act, practice or omission that constitutes fraud; or

(B) Makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan;

(b) The carrier provides at least 30 days' advance written notice, in the form and manner prescribed by the department, to the enrollee; and

(c) The carrier provides notice of the rescission to the department in the form, manner and time frame prescribed by the department by rule.

(6) Notwithstanding any provision of subsection (3) of this section to the contrary, a carrier may not rescind a small employer health benefit plan unless:

(a) The small employer or a representative of the small employer:

(A) Performs an act, practice or omission that constitutes fraud; or

(B) Makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan;

(b) The carrier provides at least 30 days' advance written notice, in the form and manner prescribed by the department, to each plan enrollee who would be affected by the rescission of coverage; and

(c) The carrier provides notice of the rescission to the department in the form, manner and time

frame prescribed by the department by rule.

(7)(a) A carrier may continue to enforce reasonable employer participation and contribution requirements on small employers. However, participation and contribution requirements shall be applied uniformly among all small employer groups with the same number of eligible employees applying for coverage or receiving coverage from the carrier. In determining minimum participation requirements, a carrier shall count only those employees who are not covered by an existing group health benefit plan, Medicaid, Medicare, TRICARE, Indian Health Service or a publicly sponsored or subsidized health plan, including but not limited to the medical assistance program under ORS chapter 414.

(b) A carrier may not deny a small employer's application for coverage under a health benefit plan based on participation or contribution requirements but may require small employers that do not meet participation or contribution requirements to enroll during the open enrollment period beginning November 15 and ending December 15.

(8) Premium rates for small employer health benefit plans, except grandfathered health plans, [*shall be*] **are** subject to the following provisions:

(a) Each carrier must file with the department the initial geographic average rate and any changes in the geographic average rate with respect to each health benefit plan issued by the carrier to small employers.

(b)(A) The variations in premium rates charged during a rating period for health benefit plans issued to small employers [*shall*] **must** be based solely on the factors specified in subparagraph (B) of this paragraph. A carrier may elect which of the factors specified in subparagraph (B) of this paragraph apply to premium rates for health benefit plans for small employers. All other factors must be applied in the same actuarially sound way to all small employer health benefit plans.

(B) The variations in premium rates described in subparagraph (A) of this paragraph may be based only on one or more of the following factors as prescribed by the department by rule:

(i) The ages of enrolled employees and their dependents, except that the rate for adults may not vary by more than three to one;

(ii) The level at which enrolled employees and [*their*] dependents **of enrolled employees who are** 18 years of age and older engage in tobacco use, except that the rate may not vary by more than 1.5 to one; and

(iii) Adjustments to reflect differences in family composition.

(C) A carrier shall apply the carrier's schedule of premium rate variations as approved by the department and in accordance with this paragraph. Except as otherwise provided in this section, the premium rate established by a carrier for a small employer health benefit plan [*shall apply*] **applies** uniformly to all employees of the small employer enrolled in that plan.

(c) Except as provided in paragraph (b) of this subsection, the variation in premium rates between different health benefit plans offered by a carrier to small employers must be based solely on objective differences in plan design or coverage, age, tobacco use and family composition and must not include differences based on the risk characteristics of groups assumed to select a particular health benefit plan.

(d) A carrier may not increase the rates of a health benefit plan issued to a small employer more than once in a 12-month period. Annual rate increases [*shall be*] **are** effective on the plan anniversary date of the health benefit plan issued to a small employer. The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(A) The percentage change in the geographic average rate measured from the first day of the prior rating period to the first day of the new period; and

(B) Any adjustment attributable to changes in age and differences in family composition.

(9) Premium rates for grandfathered health plans [*shall be*] **are** subject to requirements prescribed by the department by rule.

(10) In connection with the offering for sale of any health benefit plan to a small employer, each carrier shall make a reasonable disclosure as part of [*its*] **the carrier's** solicitation and sales materials of:

(a) The full array of health benefit plans that are offered to small employers by the carrier;

(b) The authority of the carrier to adjust rates and premiums, and the extent to which the carrier considers age, tobacco use, family composition and geographic factors in establishing and adjusting rates and premiums; and

(c) The benefits and premiums for all health insurance coverage for which the employer is qualified.

(11)(a) Each carrier shall maintain at [*its*] **the carrier's** principal place of business a complete and detailed description of [*its*] **the carrier's** rating practices and renewal underwriting practices relating to [*its*] **the carrier's** small employer health benefit plans, including information and documentation that demonstrate that [*its*] **the carrier's** rating methods and practices are based upon commonly accepted actuarial practices and are in accordance with sound actuarial principles.

(b) A carrier offering a small employer health benefit plan shall file with the department at least once every 12 months an actuarial certification that the carrier is in compliance with ORS 743B.010 to 743B.013 and that the rating methods of the carrier are actuarially sound. Each certification [*shall*] **must** be in a uniform form and manner and [*shall*] **must** contain such information as specified by the department. [*A copy of each certification shall be retained by*] The carrier [*at its*] **shall retain a copy of each certification at the carrier's** principal place of business. A carrier is not required to file the actuarial certification under this paragraph if the department has approved the carrier's rate filing within the preceding 12-month period.

(c) A carrier shall make the information and documentation described in paragraph (a) of this subsection available to the department upon request. Except as provided in ORS 743.018 and except in cases of violations of ORS 743B.010 to 743B.013, the information [*shall be considered*] **is** proprietary and trade secret information and [*shall not be*] **is not** subject to disclosure to persons outside the department except as agreed to by the carrier or as ordered by a court of competent jurisdiction.

(12) A carrier [*shall*] **may** not provide any financial or other incentive to any insurance producer that would encourage the insurance producer to sell health benefit plans of the carrier to small employer groups based on a small employer group's anticipated claims experience.

(13) For purposes of this section, the date a small employer health benefit plan is continued [*shall be*] **is** the anniversary date of the first issuance of the health benefit plan.

(14) A carrier [*must*] **shall** include a provision that offers coverage to all eligible employees of a small employer and to all dependents of the eligible employees to the extent the employer chooses to offer coverage to dependents.

(15) All small employer health benefit plans [*shall*] **must** contain special enrollment periods during which eligible employees and dependents may enroll for coverage, as provided by federal law and rules adopted by the department.

(16) A small employer health benefit plan may not impose annual or lifetime limits on the dollar amount of essential health benefits.

SECTION 16a. If Senate Bill 754 becomes law, section 16 of this 2017 Act (amending ORS 743B.013) is repealed and ORS 743B.013, as amended by section 23, chapter ___, Oregon Laws 2017 (Enrolled Senate Bill 754), is amended to read:

743B.013. (1) A health benefit plan issued to a small employer:

(a) Other than a grandfathered health plan, must cover essential health benefits consistent with 42 U.S.C. 300gg-11.

(b) May require an affiliation period that does not exceed two months for an enrollee or 90 days for a late enrollee.

(c) May not apply a preexisting condition exclusion to any enrollee.

(2) Late enrollees in a small employer health benefit plan may be subjected to a group eligibility waiting period that does not exceed 90 days.

(3) Each small employer health benefit plan [*shall be*] **is** renewable with respect to all eligible enrollees at the option of the policyholder, small employer or contract holder unless:

(a) The policyholder, small employer or contract holder fails to pay the required premiums.

(b) The policyholder, small employer or contract holder or, with respect to coverage of individual enrollees, an enrollee or a representative of an enrollee engages in fraud or makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan.

(c) The number of enrollees covered under the plan is less than the number or percentage of enrollees required by participation requirements under the plan.

(d) The small employer fails to comply with the contribution requirements under the health benefit plan.

(e) The carrier discontinues both offering and renewing all of [*its*] **the carrier's** small employer health benefit plans in this state or in a specified service area within this state. In order to discontinue plans under this paragraph, the carrier:

(A) Must give notice of the decision to the Department of Consumer and Business Services and to all policyholders covered by the plans;

(B) May not cancel coverage under the plans for 180 days after the date of the notice required under subparagraph (A) of this paragraph if coverage is discontinued in the entire state or[*, except as provided in subparagraph (C) of this paragraph,*] in a specified service area[*; and*]**, except that:**

(i) The carrier shall cancel coverage in accordance with subparagraph (C) of this paragraph if the cancellation is for a specified service area in the circumstances described in subparagraph (C) of this paragraph; and

(ii) The Director of the Department of Consumer and Business Services may specify a cancellation date other than the cancellation date specified in this subparagraph if the carrier is subject to a delinquency proceeding, as defined in ORS 734.014; and

(C) May not cancel coverage under the plans for 90 days after the date of the notice required under subparagraph (A) of this paragraph if coverage is discontinued in a specified service area because of an inability to reach an agreement with the health care providers or organization of health care providers to provide services under the plans within the service area.

(f) The carrier discontinues both offering and renewing a small employer health benefit plan in a specified service area within this state because of an inability to reach an agreement with the health care providers or organization of health care providers to provide services under the plan within the service area. In order to discontinue a plan under this paragraph, the carrier:

(A) Must give notice to the department and to all policyholders covered by the plan;

(B) May not cancel coverage under the plan for 90 days after the date of the notice required

under subparagraph (A) of this paragraph; and

(C) Must offer in writing to each small employer covered by the plan, all other small employer health benefit plans that the carrier offers to small employers in the specified service area. The carrier shall issue any such plans pursuant to the provisions of ORS 743B.010 to 743B.013. The carrier shall offer the plans at least 90 days prior to discontinuation.

(g) The carrier discontinues both offering and renewing a health benefit plan, other than a grandfathered health plan, for all small employers in this state or in a specified service area within this state, other than a plan discontinued under paragraph (f) of this subsection.

(h) The carrier discontinues both offering and renewing a grandfathered health plan for all small employers in this state or in a specified service area within this state, other than a plan discontinued under paragraph (f) of this subsection.

(i) With respect to plans that are being discontinued under paragraph (g) or (h) of this subsection, the carrier must:

(A) Offer in writing to each small employer covered by the plan, all other health benefit plans that the carrier offers to small employers in the specified service area.

(B) Issue any such plans pursuant to the provisions of ORS 743B.010 to 743B.013.

(C) Offer the plans at least 90 days prior to discontinuation.

(D) Act uniformly without regard to the claims experience of the affected policyholders or the health status of any current or prospective enrollee.

(j) The Director of the Department of Consumer and Business Services orders the carrier to discontinue coverage in accordance with procedures specified or approved by the director upon finding that the continuation of the coverage would:

(A) Not be in the best interests of the enrollees; or

(B) Impair the carrier's ability to meet contractual obligations.

(k) In the case of a small employer health benefit plan that delivers covered services through a specified network of health care providers, there is no longer any enrollee who lives, resides or works in the service area of the provider network.

(L) In the case of a health benefit plan that is offered in the small employer market only to one or more bona fide associations, the membership of an employer in the association ceases and the termination of coverage is not related to the health status of any enrollee.

(4) A carrier may modify a small employer health benefit plan at the time of coverage renewal. The modification is not a discontinuation of the plan under subsection (3)(e), (g) and (h) of this section.

(5) Notwithstanding any provision of subsection (3) of this section to the contrary, a carrier may not rescind the coverage of an enrollee in a small employer health benefit plan unless:

(a) The enrollee or a person seeking coverage on behalf of the enrollee:

(A) Performs an act, practice or omission that constitutes fraud; or

(B) Makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan;

(b) The carrier provides at least 30 days' advance written notice, in the form and manner prescribed by the department, to the enrollee; and

(c) The carrier provides notice of the rescission to the department in the form, manner and time frame prescribed by the department by rule.

(6) Notwithstanding any provision of subsection (3) of this section to the contrary, a carrier may not rescind a small employer health benefit plan unless:

(a) The small employer or a representative of the small employer:

(A) Performs an act, practice or omission that constitutes fraud; or

(B) Makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan;

(b) The carrier provides at least 30 days' advance written notice, in the form and manner prescribed by the department, to each plan enrollee who would be affected by the rescission of coverage; and

(c) The carrier provides notice of the rescission to the department in the form, manner and time frame prescribed by the department by rule.

(7)(a) A carrier may continue to enforce reasonable employer participation and contribution requirements on small employers. However, participation and contribution requirements shall be applied uniformly among all small employer groups with the same number of eligible employees applying for coverage or receiving coverage from the carrier. In determining minimum participation requirements, a carrier shall count only those employees who are not covered by an existing group health benefit plan, Medicaid, Medicare, TRICARE, Indian Health Service or a publicly sponsored or subsidized health plan, including but not limited to the medical assistance program under ORS chapter 414.

(b) A carrier may not deny a small employer's application for coverage under a health benefit plan based on participation or contribution requirements but may require small employers that do not meet participation or contribution requirements to enroll during the open enrollment period beginning November 15 and ending December 15.

(8) Premium rates for small employer health benefit plans, except grandfathered health plans, [*shall be*] **are** subject to the following provisions:

(a) Each carrier must file with the department the initial geographic average rate and any changes in the geographic average rate with respect to each health benefit plan issued by the carrier to small employers.

(b)(A) The variations in premium rates charged during a rating period for health benefit plans issued to small employers [*shall*] **must** be based solely on the factors specified in subparagraph (B) of this paragraph. A carrier may elect which of the factors specified in subparagraph (B) of this paragraph apply to premium rates for health benefit plans for small employers. All other factors must be applied in the same actuarially sound way to all small employer health benefit plans.

(B) The variations in premium rates described in subparagraph (A) of this paragraph may be based only on one or more of the following factors as prescribed by the department by rule:

(i) The ages of enrolled employees and their dependents, except that the rate for adults may not vary by more than three to one;

(ii) The level at which enrolled employees and [*their*] dependents **of enrolled employees** engage in tobacco use, except that the rate may not vary by more than 1.5 to one; and

(iii) Adjustments to reflect differences in family composition.

(C) A carrier shall apply the carrier's schedule of premium rate variations as approved by the department and in accordance with this paragraph. Except as otherwise provided in this section, the premium rate established by a carrier for a small employer health benefit plan [*shall apply*] **applies** uniformly to all employees of the small employer enrolled in that plan.

(c) Except as provided in paragraph (b) of this subsection, the variation in premium rates between different health benefit plans offered by a carrier to small employers must be based solely on objective differences in plan design or coverage, age, tobacco use and family composition and must

not include differences based on the risk characteristics of groups assumed to select a particular health benefit plan.

(d) A carrier may not increase the rates of a health benefit plan issued to a small employer more than once in a 12-month period. Annual rate increases [*shall be*] **are** effective on the plan anniversary date of the health benefit plan issued to a small employer. The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(A) The percentage change in the geographic average rate measured from the first day of the prior rating period to the first day of the new period; and

(B) Any adjustment attributable to changes in age and differences in family composition.

(9) Premium rates for grandfathered health plans [*shall be*] **are** subject to requirements prescribed by the department by rule.

(10) In connection with the offering for sale of any health benefit plan to a small employer, each carrier shall make a reasonable disclosure as part of [*its*] **the carrier's** solicitation and sales materials of:

(a) The full array of health benefit plans that are offered to small employers by the carrier;

(b) The authority of the carrier to adjust rates and premiums, and the extent to which the carrier considers age, tobacco use, family composition and geographic factors in establishing and adjusting rates and premiums; and

(c) The benefits and premiums for all health insurance coverage for which the employer is qualified.

(11)(a) Each carrier shall maintain at [*its*] **the carrier's** principal place of business a complete and detailed description of [*its*] **the carrier's** rating practices and renewal underwriting practices relating to [*its*] **the carrier's** small employer health benefit plans, including information and documentation that demonstrate that [*its*] **the carrier's** rating methods and practices are based upon commonly accepted actuarial practices and are in accordance with sound actuarial principles.

(b) A carrier offering a small employer health benefit plan shall file with the department at least once every 12 months an actuarial certification that the carrier is in compliance with ORS 743B.010 to 743B.013 and that the rating methods of the carrier are actuarially sound. Each certification [*shall*] **must** be in a uniform form and manner and [*shall*] **must** contain such information as specified by the department. [*A copy of each certification shall be retained by*] The carrier [*at its*] **shall retain a copy of each certification at the carrier's** principal place of business. A carrier is not required to file the actuarial certification under this paragraph if the department has approved the carrier's rate filing within the preceding 12-month period.

(c) A carrier shall make the information and documentation described in paragraph (a) of this subsection available to the department upon request. Except as provided in ORS 743.018 and except in cases of violations of ORS 743B.010 to 743B.013, the information [*shall be considered*] **is** proprietary and trade secret information and [*shall not be*] **is not** subject to disclosure to persons outside the department except as agreed to by the carrier or as ordered by a court of competent jurisdiction.

(12) A carrier [*shall*] **may** not provide any financial or other incentive to any insurance producer that would encourage the insurance producer to sell health benefit plans of the carrier to small employer groups based on a small employer group's anticipated claims experience.

(13) For purposes of this section, the date a small employer health benefit plan is continued [*shall be*] **is** the anniversary date of the first issuance of the health benefit plan.

(14) A carrier [*must*] **shall** include a provision that offers coverage to all eligible employees of

a small employer and to all dependents of the eligible employees to the extent the employer chooses to offer coverage to dependents.

(15) All small employer health benefit plans [*shall*] **must** contain special enrollment periods during which eligible employees and dependents may enroll for coverage, as provided by federal law and rules adopted by the department.

(16) A small employer health benefit plan may not impose annual or lifetime limits on the dollar amount of essential health benefits.

SECTION 17. ORS 743B.105 is amended to read:

743B.105. The following requirements apply to all group health benefit plans other than small employer health benefit plans covering two or more certificate holders:

(1) A carrier offering a group health benefit plan may not decline to offer coverage to any eligible prospective enrollee and may not impose different terms or conditions on the coverage, premiums or contributions of any enrollee in the group that are based on the actual or expected health status of the enrollee.

(2) A group health benefit plan may not apply a preexisting condition exclusion to any enrollee but may impose:

(a) An affiliation period that does not exceed two months for an enrollee or three months for a late enrollee; or

(b) A group eligibility waiting period for late enrollees that does not exceed 90 days.

(3) Each group health benefit plan shall contain a special enrollment period during which eligible employees and dependents may enroll for coverage, as provided by federal law and rules adopted by the Department of Consumer and Business Services.

(4)(a) A carrier shall issue to a group any of the carrier's group health benefit plans offered by the carrier for which the group is eligible, if the group applies for the plan, agrees to make the required premium payments and agrees to satisfy the other requirements of the plan.

(b) The department may waive the requirements of this subsection if the department finds that issuing a plan to a group or groups would endanger the carrier's ability to fulfill [*its*] **the carrier's** contractual obligations or result in financial impairment of the carrier.

(5) Each group health benefit plan shall be renewable with respect to all eligible enrollees at the option of the policyholder unless:

(a) The policyholder fails to pay the required premiums.

(b) The policyholder or, with respect to coverage of individual enrollees, an enrollee or a representative of an enrollee engages in fraud or makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan.

(c) The number of enrollees covered under the plan is less than the number or percentage of enrollees required by participation requirements under the plan.

(d) The policyholder fails to comply with the contribution requirements under the plan.

(e) The carrier discontinues both offering and renewing, all of [*its*] **the carrier's** group health benefit plans in this state or in a specified service area within this state. In order to discontinue plans under this paragraph, the carrier:

(A) Must give notice of the decision to the department and to all policyholders covered by the plans;

(B) May not cancel coverage under the plans for 180 days after the date of the notice required under subparagraph (A) of this paragraph if coverage is discontinued in the entire state or[*, except as provided in subparagraph (C) of this paragraph,*] in a specified service area[*; and*]**, except that:**

(i) The carrier shall cancel coverage in accordance with subparagraph (C) of this paragraph if the cancellation is for a specified service area in the circumstances described in subparagraph (C) of this paragraph; and

(ii) The Director of the Department of Consumer and Business Services may specify a cancellation date other than the cancellation date specified in this subparagraph if the carrier is subject to a delinquency proceeding, as defined in ORS 734.014; and

(C) May not cancel coverage under the plans for 90 days after the date of the notice required under subparagraph (A) of this paragraph if coverage is discontinued in a specified service area because of an inability to reach an agreement with the health care providers or organization of health care providers to provide services under the plans within the service area.

(f) The carrier discontinues both offering and renewing a group health benefit plan in a specified service area within this state because of an inability to reach an agreement with the health care providers or organization of health care providers to provide services under the plan within the service area. In order to discontinue a plan under this paragraph, the carrier:

(A) Must give notice of the decision to the department and to all policyholders covered by the plan;

(B) May not cancel coverage under the plan for 90 days after the date of the notice required under subparagraph (A) of this paragraph; and

(C) Must offer in writing to each policyholder covered by the plan, all other group health benefit plans that the carrier offers in the specified service area. The carrier shall offer the plans at least 90 days prior to discontinuation.

(g) The carrier discontinues both offering and renewing a group health benefit plan, other than a grandfathered health plan, for all groups in this state or in a specified service area within this state, other than a plan discontinued under paragraph (f) of this subsection.

(h) The carrier discontinues both offering and renewing a grandfathered health plan for all groups in this state or in a specified service are within this state, other than a plan discontinued under paragraph (f) of this subsection.

(i) With respect to plans that are being discontinued under paragraph (g) or (h) of this subsection, the carrier must:

(A) Offer in writing to each policyholder covered by the plan, one or more health benefit plans that the carrier offers to groups in the specified service area.

(B) Offer the plans at least 90 days prior to discontinuation.

(C) Act uniformly without regard to the claims experience of the affected policyholders or the health status of any current or prospective enrollee.

(j) The director [*of the Department of Consumer and Business Services*] orders the carrier to discontinue coverage in accordance with procedures specified or approved by the director upon finding that the continuation of the coverage would:

(A) Not be in the best interests of the enrollees; or

(B) Impair the carrier's ability to meet contractual obligations.

(k) In the case of a group health benefit plan that delivers covered services through a specified network of health care providers, there is no longer any enrollee who lives, resides or works in the service area of the provider network.

(L) In the case of a health benefit plan that is offered in the group market only to one or more bona fide associations, the membership of an employer in the association ceases and the termination of coverage is not related to the health status of any enrollee.

(6) A carrier may modify a group health benefit plan at the time of coverage renewal. The modification is not a discontinuation of the plan under subsection (5)(e), (g) and (h) of this section.

(7) Notwithstanding any provision of subsection (5) of this section to the contrary, a carrier may not rescind the coverage of an enrollee under a group health benefit plan unless:

(a) The enrollee:

(A) Performs an act, practice or omission that constitutes fraud; or

(B) Makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan;

(b) The carrier provides at least 30 days' advance written notice, in the form and manner prescribed by the department, to the enrollee; and

(c) The carrier provides notice of the rescission to the department in the form, manner and time frame prescribed by the department by rule.

(8) Notwithstanding any provision of subsection (5) of this section to the contrary, a carrier may not rescind a group health benefit plan unless:

(a) The plan sponsor or a representative of the plan sponsor:

(A) Performs an act, practice or omission that constitutes fraud; or

(B) Makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan;

(b) The carrier provides at least 30 days' advance written notice, in the form and manner prescribed by the department, to each plan enrollee who would be affected by the rescission of coverage; and

(c) The carrier provides notice of the rescission to the department in the form, manner and time frame prescribed by the department by rule.

(9) A group health benefit plan may not impose annual or lifetime limits on the dollar amount of essential health benefits.

SECTION 18. ORS 743B.125 is amended to read:

743B.125. (1) With respect to coverage under an individual health benefit plan, a carrier may not impose an individual coverage waiting period.

(2) With respect to individual coverage under a grandfathered health plan, a carrier:

(a) May impose an exclusion period for specified covered services applicable to all individuals enrolling for the first time in the individual health benefit plan.

(b) May not impose a preexisting condition exclusion unless the exclusion complies with the following requirements:

(A) The exclusion applies only to a condition for which medical advice, diagnosis, care or treatment was recommended or received during the six-month period immediately preceding the individual's effective date of coverage.

(B) The exclusion expires no later than six months after the individual's effective date of coverage.

(3) An individual health benefit plan other than a grandfathered health plan must cover, at a minimum, all essential health benefits.

(4) A carrier shall renew an individual health benefit plan, including a health benefit plan issued through a bona fide association, unless:

(a) The policyholder fails to pay the required premiums.

(b) The policyholder or a representative of the policyholder engages in fraud or makes an intentional misrepresentation of a material fact as prohibited by the terms of the policy.

(c) The carrier discontinues both offering and renewing all of [*its*] **the carrier's** individual health benefit plans in this state or in a specified service area within this state. In order to discontinue the plans under this paragraph, the carrier:

(A) [*Must*] **Shall** give notice of the decision to the Department of Consumer and Business Services and to all policyholders covered by the plans;

(B) May not cancel coverage under the plans for 180 days after the date of the notice required under subparagraph (A) of this paragraph if coverage is discontinued in the entire state or[*, except as provided in subparagraph (C) of this paragraph,*] in a specified service area[*; and*]**, except that:**

(i) The carrier shall cancel coverage in accordance with subparagraph (C) of this paragraph if the cancellation is for a specified service area in the circumstances described in subparagraph (C) of this paragraph; and

(ii) The Director of the Department of Consumer and Business Services may specify a cancellation date other than the cancellation date specified in this subparagraph if the carrier is subject to a delinquency proceeding, as defined in ORS 734.014; and

(C) May not cancel coverage under the plans for 90 days after the date of the notice required under subparagraph (A) of this paragraph if coverage is discontinued in a specified service area because of an inability to reach an agreement with the health care providers or organization of health care providers to provide services under the plans within the service area.

(d) The carrier discontinues both offering and renewing an individual health benefit plan in a specified service area within this state because of an inability to reach an agreement with the health care providers or organization of health care providers to provide services under the plan within the service area. In order to discontinue a plan under this paragraph, the carrier:

(A) [*Must*] **Shall** give notice of the decision to the department and to all policyholders covered by the plan;

(B) May not cancel coverage under the plan for 90 days after the date of the notice required under subparagraph (A) of this paragraph; and

(C) [*Must*] **Shall** offer in writing to each policyholder covered by the plan, all other individual health benefit plans that the carrier offers in the specified service area. The carrier shall offer the plans at least 90 days prior to discontinuation.

(e) The carrier discontinues both offering and renewing an individual health benefit plan, other than a grandfathered health plan, for all individuals in this state or in a specified service area within this state, other than a plan discontinued under paragraph (d) of this subsection.

(f) The carrier discontinues both offering and renewing a grandfathered health plan for all individuals in this state or in a specified service area within this state, other than a plan discontinued under paragraph (d) of this subsection.

(g) With respect to plans that are being discontinued under paragraph (e) or (f) of this subsection, the carrier [*must*] **shall**:

(A) Offer in writing to each policyholder covered by the plan, all health benefit plans that the carrier offers to individuals in the specified service area.

(B) Offer the plans at least 90 days prior to discontinuation.

(C) Act uniformly without regard to the claims experience of the affected policyholders or the health status of any current or prospective enrollee.

(h) The Director of the Department of Consumer and Business Services orders the carrier to discontinue coverage in accordance with procedures specified or approved by the director upon finding that the continuation of the coverage would:

(A) Not be in the best interests of the enrollee; or

(B) Impair the carrier's ability to meet [*its*] **the carrier's** contractual obligations.

(i) In the case of an individual health benefit plan that delivers covered services through a specified network of health care providers, the enrollee no longer lives, resides or works in the service area of the provider network and the termination of coverage is not related to the health status of any enrollee.

(j) In the case of a health benefit plan that is offered in the individual market only through one or more bona fide associations, the membership of an individual in the association ceases and the termination of coverage is not related to the health status of any enrollee.

(5) A carrier may modify an individual health benefit plan at the time of coverage renewal. The modification is not a discontinuation of the plan under subsection (4)(c), (e) and (f) of this section.

(6) Notwithstanding any other provision of this section, and subject to the provisions of ORS 743B.310 (2) and (4), a carrier may rescind an individual health benefit plan if the policyholder or a representative of the policyholder:

(a) Performs an act, practice or omission that constitutes fraud; or

(b) Makes an intentional misrepresentation of a material fact as prohibited by the terms of the policy.

(7) A carrier that continues to offer coverage in the individual market in this state is not required to offer coverage in all of the carrier's individual health benefit plans. However, if a carrier elects to continue a plan that is closed to new individual policyholders instead of offering alternative coverage in [*its*] **the carrier's** other individual health benefit plans, the coverage for all existing policyholders in the closed plan is renewable in accordance with subsection (4) of this section.

(8) An individual health benefit plan may not impose annual or lifetime limits on the dollar amount of essential health benefits.

(9) A grandfathered health plan may not impose lifetime limits on the dollar amount of essential health benefits.

(10) This section does not require a carrier to actively market, offer, issue or accept applications for:

(a) A bona fide association health benefit plan from individuals who are not members of the bona fide association; or

(b) A grandfathered health plan from individuals who are not eligible for coverage under the plan.

SECTION 19. ORS 750.015 is amended to read:

750.015. (1) Except as provided in subsection (2) of this section, [*not less than*] **at least** one-third of the group of persons vested with [*the management of*] **managing** the affairs of a health care service contractor, as defined in ORS 750.005 (4)(a), [*shall*] **must** be representatives of the public who are not**:**

(a) Practicing doctors**;** or

(b) Employees or trustees of a participant hospital.

(2)(a) Notwithstanding subsection (1) of this section, the group of persons vested with [*the management of*] **managing** the affairs of a nonprofit private organization described in **paragraph (b) of** this subsection [*shall*] **must** have at least two representatives of the public who are not**:**

(A) Practicing doctors, as defined in ORS 750.005[,]**;** or

(B) Employees or trustees of a participant hospital.

(b) This subsection applies to a nonprofit private organization that is a health maintenance or-

ganization, as defined in ORS 442.015, that is controlled by a single nonprofit hospital or by a group of nonprofit hospitals under common ownership and that operates in a county with a population of 200,000 or more.

SECTION 20. ORS 750.055, as amended by section 7, chapter 59, Oregon Laws 2015, is amended to read:

750.055. (1) The following provisions of the Insurance Code apply to health care service contractors to the extent not inconsistent with the express provisions of ORS 750.005 to 750.095:

(a) ORS 705.137, 705.139, 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.592, 731.594, 731.640 to 731.652, 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804, 731.844 to 731.992, 731.870 and 743A.252.

(b) ORS 731.485, except in the case of a group practice health maintenance organization that is federally qualified pursuant to Title XIII of the Public Health Service Act and that wholly owns and operates an in-house drug outlet.

(c) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.592, not including ORS 732.582.

(d) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695 to 733.780.

(e) ORS chapter 734.

(f) ORS 735.600 to 735.650.

(g) ORS 742.001 to 742.009, 742.013, 742.061, 742.065, 742.150 to 742.162, 742.400, 742.520 to 742.540, 743.004, 743.008, 743.010, 743.018, 743.022, 743.023, 743.028, 743.029, 743.038, 743.040, 743.044, 743.050, 743.100 to 743.109, 743.402, 743.406, 743.417, 743.472, 743.492, 743.495, 743.498, 743.522, 743.523, 743.524, 743.526, 743.535, 743.550, 743.650 to 743.656, 743.680 to 743.689, 743.788, 743.790, 743A.010, 743A.012, 743A.020, 743A.034, 743A.036, 743A.048, 743A.051, 743A.058, 743A.062, 743A.064, 743A.065, 743A.066, 743A.068, 743A.070, 743A.080, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.105, 743A.110, 743A.140, 743A.141, 743A.144, 743A.148, 743A.150, 743A.160, 743A.164, 743A.168, 743A.170, 743A.175, 743A.184, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250, 743B.003 to 743B.127, 743B.195 to 743B.206, 743B.220, 743B.222, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253, 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.300, 743B.310, 743B.320, 743B.323, 743B.330, 743B.340, 743B.341, 743B.343 to 743B.347, 743B.400, 743B.403, 743B.407, 743B.420, 743B.423, 743B.450, 743B.451, 743B.452, 743B.453, 743B.470, 743B.475, 743B.505, 743B.550, 743B.555, 743B.601 and 743B.800 and section 2, chapter 771, Oregon Laws 2013.

(h) The provisions of ORS chapter 744 relating to the regulation of insurance producers and third party administrators.

(i) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610, 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and 746.690.

(j) ORS 743A.024, except in the case of group practice health maintenance organizations that are federally qualified pursuant to Title XIII of the Public Health Service Act unless the patient is referred by a physician, physician assistant or nurse practitioner associated with a group practice health maintenance organization.

(2) For the purposes of this section, health care service contractors [*shall be deemed*] **are** insurers.

(3) Any for-profit health care service contractor organized under the laws of any other state that is not governed by the insurance laws of the other state is subject to all requirements of ORS

chapter 732.

(4)(a) A health care service contractor is a domestic insurance company for the purpose of determining whether the health care service contractor is a debtor, as defined in 11 U.S.C. 109.

(b) A health care service contractor's classification as a domestic insurance company under paragraph (a) of this subsection does not subject the health care service contractor to ORS 734.510 to 734.710.

[*(4)*] **(5)** The Director of the Department of Consumer and Business Services may, after notice and hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025 and 750.045 that are [*deemed*] necessary for the proper administration of these provisions.

SECTION 21. ORS 750.055, as amended by section 33, chapter 698, Oregon Laws 2013, section 6, chapter 25, Oregon Laws 2014, section 81, chapter 45, Oregon Laws 2014, section 8, chapter 59, Oregon Laws 2015, section 6, chapter 100, Oregon Laws 2015, section 6, chapter 224, Oregon Laws 2015, section 10, chapter 362, Oregon Laws 2015, section 9, chapter 470, Oregon Laws 2015, and section 29, chapter 515, Oregon Laws 2015, is amended to read:

750.055. (1) The following provisions of the Insurance Code apply to health care service contractors to the extent not inconsistent with the express provisions of ORS 750.005 to 750.095:

(a) ORS 705.137, 705.139, 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.592, 731.594, 731.640 to 731.652, 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804, 731.844 to 731.992, 731.870 and 743A.252.

(b) ORS 731.485, except in the case of a group practice health maintenance organization that is federally qualified pursuant to Title XIII of the Public Health Service Act and that wholly owns and operates an in-house drug outlet.

(c) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.592, not including ORS 732.582.

(d) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695 to 733.780.

(e) ORS chapter 734.

(f) ORS 735.600 to 735.650.

(g) ORS 742.001 to 742.009, 742.013, 742.061, 742.065, 742.150 to 742.162, 742.400, 742.520 to 742.540, 743.004, 743.008, 743.010, 743.018, 743.022, 743.023, 743.028, 743.029, 743.038, 743.040, 743.044, 743.050, 743.100 to 743.109, 743.402, 743.406, 743.417, 743.472, 743.492, 743.495, 743.498, 743.522, 743.523, 743.524, 743.526, 743.535, 743.550, 743.650 to 743.656, 743.680 to 743.689, 743.788, 743.790, 743A.010, 743A.012, 743A.020, 743A.034, 743A.036, 743A.048, 743A.051, 743A.058, 743A.062, 743A.064, 743A.065, 743A.066, 743A.068, 743A.070, 743A.080, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.105, 743A.110, 743A.140, 743A.141, 743A.144, 743A.148, 743A.150, 743A.160, 743A.164, 743A.168, 743A.170, 743A.175, 743A.184, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250, 743B.003 to 743B.127, 743B.195 to 743B.206, 743B.220, 743B.222, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253, 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.300, 743B.310, 743B.320, 743B.323, 743B.330, 743B.340, 743B.341, 743B.343 to 743B.347, 743B.400, 743B.403, 743B.407, 743B.420, 743B.423, 743B.450, 743B.451, 743B.452, 743B.453, 743B.470, 743B.475, 743B.505, 743B.550, 743B.555, 743B.601 and 743B.800 and section 2, chapter 771, Oregon Laws 2013.

(h) The provisions of ORS chapter 744 relating to the regulation of insurance producers and third party administrators.

(i) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610, 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and 746.690.

(j) ORS 743A.024, except in the case of group practice health maintenance organizations that are federally qualified pursuant to Title XIII of the Public Health Service Act unless the patient is referred by a physician, physician assistant or nurse practitioner associated with a group practice health maintenance organization.

(2) For the purposes of this section, health care service contractors [*shall be deemed*] **are** insurers.

(3) Any for-profit health care service contractor organized under the laws of any other state that is not governed by the insurance laws of the other state is subject to all requirements of ORS chapter 732.

(4)(a) A health care service contractor is a domestic insurance company for the purpose of determining whether the health care service contractor is a debtor, as defined in 11 U.S.C. 109.

(b) A health care service contractor's classification as a domestic insurance company under paragraph (a) of this subsection does not subject the health care service contractor to ORS 734.510 to 734.710.

[*(4)*] **(5)** The Director of the Department of Consumer and Business Services may, after notice and hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025 and 750.045 that are [*deemed*] necessary for the proper administration of these provisions.

SECTION 22. ORS 750.055, as amended by section 21, chapter 771, Oregon Laws 2013, section 7, chapter 25, Oregon Laws 2014, section 82, chapter 45, Oregon Laws 2014, section 9, chapter 59, Oregon Laws 2015, section 7, chapter 100, Oregon Laws 2015, section 7, chapter 224, Oregon Laws 2015, section 11, chapter 362, Oregon Laws 2015, section 10, chapter 470, Oregon Laws 2015, and section 30, chapter 515, Oregon Laws 2015, is amended to read:

750.055. (1) The following provisions of the Insurance Code apply to health care service contractors to the extent not inconsistent with the express provisions of ORS 750.005 to 750.095:

(a) ORS 705.137, 705.139, 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.592, 731.594, 731.640 to 731.652, 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804, 731.844 to 731.992, 731.870 and 743A.252.

(b) ORS 731.485, except in the case of a group practice health maintenance organization that is federally qualified pursuant to Title XIII of the Public Health Service Act and that wholly owns and operates an in-house drug outlet.

(c) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.592, not including ORS 732.582.

(d) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695 to 733.780.

(e) ORS chapter 734.

(f) ORS 735.600 to 735.650.

(g) ORS 742.001 to 742.009, 742.013, 742.061, 742.065, 742.150 to 742.162, 742.400, 742.520 to 742.540, 743.004, 743.008, 743.010, 743.018, 743.022, 743.023, 743.028, 743.029, 743.038, 743.040, 743.044, 743.050, 743.100 to 743.109, 743.402, 743.406, 743.417, 743.472, 743.492, 743.495, 743.498, 743.522, 743.523, 743.524, 743.526, 743.535, 743.550, 743.650 to 743.656, 743.680 to 743.689, 743.788, 743.790, 743A.010, 743A.012, 743A.020, 743A.034, 743A.036, 743A.048, 743A.051, 743A.058, 743A.062, 743A.064,

743A.065, 743A.066, 743A.068, 743A.070, 743A.080, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.105, 743A.110, 743A.140, 743A.141, 743A.144, 743A.148, 743A.150, 743A.160, 743A.164, 743A.168, 743A.170, 743A.175, 743A.184, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250, 743B.003 to 743B.127, 743B.195 to 743B.206, 743B.220, 743B.222, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253, 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.300, 743B.310, 743B.320, 743B.323, 743B.330, 743B.340, 743B.341, 743B.343 to 743B.347, 743B.400, 743B.403, 743B.407, 743B.420, 743B.423, 743B.450, 743B.451, 743B.452, 743B.453, 743B.470, 743B.475, 743B.505, 743B.550, 743B.555, 743B.601 and 743B.800.

(h) The provisions of ORS chapter 744 relating to the regulation of insurance producers and third party administrators.

(i) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610, 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and 746.690.

(j) ORS 743A.024, except in the case of group practice health maintenance organizations that are federally qualified pursuant to Title XIII of the Public Health Service Act unless the patient is referred by a physician, physician assistant or nurse practitioner associated with a group practice health maintenance organization.

(2) For the purposes of this section, health care service contractors [*shall be deemed*] **are** insurers.

(3) Any for-profit health care service contractor organized under the laws of any other state that is not governed by the insurance laws of the other state is subject to all requirements of ORS chapter 732.

(4)(a) A health care service contractor is a domestic insurance company for the purpose of determining whether the health care service contractor is a debtor, as defined in 11 U.S.C. 109.

(b) A health care service contractor's classification as a domestic insurance company under paragraph (a) of this subsection does not subject the health care service contractor to ORS 734.510 to 734.710.

[*(4)*] **(5)** The Director of the Department of Consumer and Business Services may, after notice and hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025 and 750.045 that are [*deemed*] necessary for the proper administration of these provisions.

SECTION 23. ORS 750.085 is amended to read:

750.085. (1) [*When*] **If** a final order of liquidation with a finding of insolvency has been entered with respect to a health care service contractor by a court of competent jurisdiction in the domicile of the health care service contractor, subscribers of the health care service contractor [*shall*] **must** be offered replacement coverage as provided in this section.

(2) All insurers and health care service contractors that participated with the insolvent health care service contractor in the open enrollment process at the last regular open enrollment period for a group shall offer members of the group that are subscribers of the insolvent health care service contractor an open enrollment period [*of 30 days*] **that the Director of the Department of Consumer and Business Services establishes by rule**, commencing on the date on which the final order of liquidation with a finding of insolvency was entered. Each of the insurers and health care service contractors shall offer the subscribers of the insolvent health care service contractor the same coverages and rates that the insurer or health care service contractor had offered to members of the group at [*its*] **the group's** last regular open enrollment period.

(3) If no other insurer or health care service contractor offered health insurance coverage to a

group or groups whose members are enrolled with the insolvent health care service contractor, or if the other insurers and health care service contractors lack sufficient health care delivery resources to assure that health care services will be available and accessible to all of the group subscribers of the insolvent health care service contractor, the Director of the Department of Consumer and Business Services shall equitably allocate the contract or contracts for the group or groups among all health care service contractors that operate within a portion of the service area of the insolvent health care service contractor. The director shall take into consideration the health care delivery resources of each health care service contractor. Each health care service contractor to which a group or groups are so allocated shall offer to each such group the existing coverage of the health care service contractor, at rates determined by the health care service contractor in accordance with [*its*] **the health care service contractor's** existing rating methodology. Each health care service contractor to whom a group or groups are allocated may reevaluate the group or groups at the end of the contractual period or at the end of six months after the allocation, whichever occurs first, in order to determine the appropriate premium for each such group.

(4) The director shall equitably allocate the nongroup subscribers of the insolvent health care service contractor that are unable to obtain other coverage among all health care service contractors that operate within a portion of the service area of the insolvent health care service contractor. The director shall take into consideration the health care delivery resources of each health care service contractor. Each health care service contractor to which nongroup subscribers are allocated shall offer [*its*] **the health care service contractor's** existing individual or conversion coverage to nongroup subscribers, at rates determined in accordance with [*its*] **the health care service contractor's** existing rating methodology. A health care service contractor that does not offer direct nongroup enrollment may aggregate all of the allocated nongroup subscribers into one group for rating and coverage purposes.

SECTION 24. (1) Sections 2, 3, 5, 6, 7 and 8 of this 2017 Act and the amendments to ORS 732.245, 732.528, 732.548, 732.588, 732.592, 732.650, 734.230, 743B.013, 743B.105, 743B.125, 750.015, 750.055 and 750.085 by sections 9 to 23 of this 2017 Act become operative January 1, 2018.

(2) The Director of the Department of Consumer and Business Services may adopt rules and take any action before the operative date specified in subsection (1) of this section that is necessary to enable the director, on and after the operative date specified in subsection (1) of this section, to exercise all of the duties, powers and functions conferred on the director by sections 2, 3, 5, 6, 7 and 8 of this 2017 Act and the amendments to ORS 732.245, 732.528, 732.548, 732.588, 732.592, 732.650, 734.230, 743B.013, 743B.105, 743B.125, 750.015, 750.055 and 750.085 by sections 9 to 23 of this 2017 Act.

SECTION 25. This 2017 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2017 Act takes effect on its passage.